

EXHIBIT 8a

FOLLOW-UP NOTICE OF AUDIT OF CLAIM**DATE OF NOTICE: AUGUST 30, 2017****RESPONSE DATE: SEPTEMBER 29, 2017****I. SETTLEMENT CLASS MEMBER INFORMATION**

Settlement Program ID	260006736		
Name	First [REDACTED]	M.I. [REDACTED]	Last [REDACTED]
Settlement Class Member Type	Retired NFL Football Player		
Primary Counsel	Lieff Cabraser Heimann & Bernstein LLP		

II. EXPLANATION AND REQUEST FOR INFORMATION

This Notice is an official communication from the Claims Administrator for the NFL Concussion Settlement Program. On 8/21/17, we sent you a Notice of Audit of Claim telling you that your claim was selected for audit under Section 10.3 of the Settlement Agreement.

We have identified additional information and/or records that we need. Please provide the requested information and/or records so that we can complete the audit and continue processing your claim. We can help if you have questions.

	What is Needed	Explanation
1.	Complete and submit to the Program the attached Health Care Provider History Form.	Under Section 10.3 of the Settlement Agreement, the Claims Administrator may require that a Settlement Class Member submit additional information as may be necessary and appropriate to audit a claim. We need a list of all health care providers seen by you in the last five years, so that we can verify your claim.
2.	Complete and submit to the Program the attached HIPAA Authorization Form for Disclosure of Protected Health Information. You should leave the Medical Provider Information section of the Form blank. We will complete this section of the Form when we obtain any necessary medical records.	Under Section 10.3 of the Settlement Agreement, the Claims Administrator may require that a Settlement Class Member submit additional information as may be necessary and appropriate to audit a claim. We need this Authorization Form so that we can obtain your medical records directly from a health care provider.
3.	Complete and submit to the Program the attached Employment History Form.	Under Section 10.3 of the Settlement Agreement, the Claims Administrator may require that a Settlement Class Member submit additional information as may be necessary and appropriate to audit a claim. We need a list of all your employers in the last five years, so that we can verify your claim.

III. HOW TO RESPOND TO THIS NOTICE

Please provide the information and/or records identified in Section II of this Notice by the Response Date stated at the top of this Notice. **If you unreasonably fail or refuse to provide us with all records and information identified in Section II of this Notice, we will deny your claim under Section 10.3(b)(ii) of the Settlement Agreement without right to an appeal.** Submit your information using one of these methods:

By Mail:

(must be postmarked on or before the deadline date)

NFL Concussion Settlement
Claims Administrator
P.O. Box 25369
Richmond, VA 23260

By Delivery:

(must be placed with the carrier on or before the deadline date)

NFL Concussion Settlement
c/o BrownGreer PLC
250 Rocketts Way
Richmond, VA 23231

If you would like to receive and submit forms like this one electronically online rather than on paper, go to www.NFLConcussionSettlement.com/Login.aspx, click the Create New User button and follow the instructions there to establish a secure online portal account with us.

IV. HOW TO CONTACT US WITH QUESTIONS OR FOR HELP

If you are represented by a lawyer, consult with your lawyer if you have questions or need assistance. If you are unrepresented and have any questions about this Notice or need help, contact us at 1-855-887-3485 or send an email to ClaimsAdministrator@NFLConcussionSettlement.com. If you are a lawyer, call or email your designated Firm Contact for assistance. For more information about the Settlement Program, visit the official website at www.NFLConcussionSettlement.com to read the Frequently Asked Questions or download a copy of the complete Settlement Agreement.

NFL CONCUSSION SETTLEMENT

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION
No. 2:12-md-02323 (E.D. Pa.)

HEALTH CARE PROVIDER HISTORY FORM

I. RETIRED NFL FOOTBALL PLAYER INFORMATION

Settlement Program ID		260006736		
Player Name	First [REDACTED]	M.I. [REDACTED]	Last [REDACTED]	Suffix

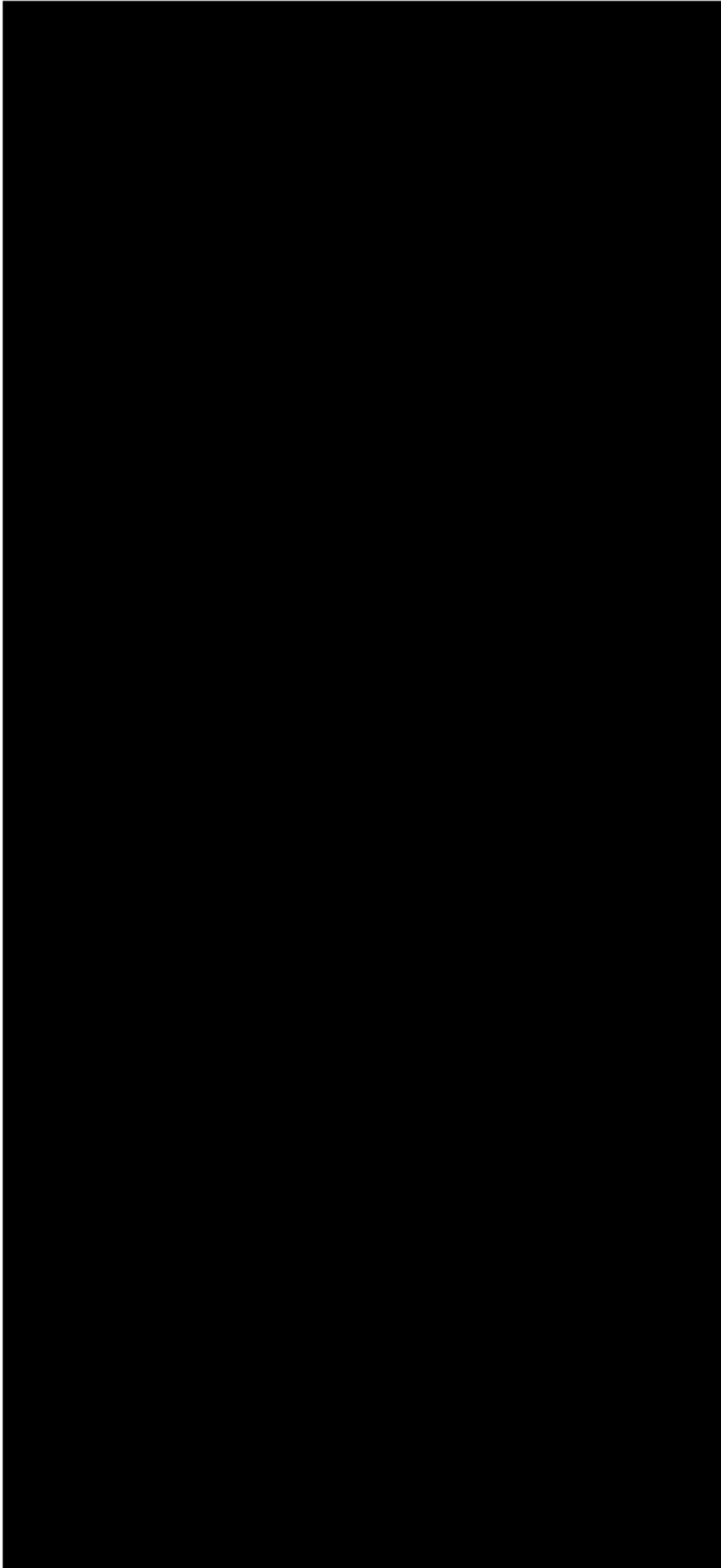
II. HEALTH CARE PROVIDERS

Provide the following information for all health care providers seen by the Retired NFL Football Player in the last five years. If you need more space, attach supplemental pages.

1.	Name:	Michael A. Lobatz, MD, APC
	[REDACTED]	
2.	Name:	Francis Conidi, MD
	[REDACTED]	
3.	Name:	Lawrence V. Tucker, MD, PLLC
	[REDACTED]	
4.	Name:	David J. Chao, MD
	[REDACTED]	

HEALTH CARE PROVIDER HISTORY FORM				
5.	Name:	James J. Chao, MD		
	Specialty:			
	Address:			
6.	Name:	Ezekiel Fink, MD, QME		
	Specialty:			
	Address:			
7.	Name:	Laura Hopper, PhD		
	Specialty:			
	Address:			
8.	Name:	SEE ATTACHMENT FOR ADDITIONAL PROVIDERS		
	Specialty:			
	Address:	Street		
		City	State	Zip Code
III. HOW TO SUBMIT THIS FORM				
Submit this Form using one of these methods:				
By Mail: (must be postmarked on or before the deadline date)		NFL Concussion Settlement Claims Administrator P.O. Box 25369 Richmond, VA 23260		
By Delivery: (must be placed with the carrier on or before the deadline date)		NFL Concussion Settlement c/o BrownGreer PLC 250 Rocketts Way Richmond, VA 23231		

Additional Healthcare Providers



This Form authorizes the disclosure of "Protected Health Information" as that term is defined in 45 C.F.R. § 160.103. Protected Health Information includes, but is not limited to, information regarding the Retired NFL Football Player's medical care, treatment, physical or mental condition, and medical expenses. By signing and submitting this Form, I authorize the Medical Provider(s) identified in Section I to release all Protected Health Information regarding my (or the Retired NFL Football Player's, if signed by a Representative Claimant) medical care, treatment, physical and mental condition, and medical expenses, to BrownGreer PLC (250 Rocketts Way Richmond, VA 23231), the Claims Administrator in the *In re: National Football League Players' Concussion Injury Litigation* Settlement Program. These records will be used or disclosed solely in connection with the NFL Concussion Settlement Program involving the Retired NFL Football Player named in Section II.

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Page 1 of 3


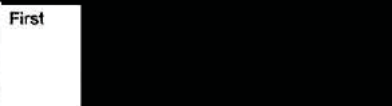


AUDIT PROCESS HIPAA AUTHORIZATION FORM**III. AUTHORIZATION**

By signing below, I acknowledge and understand all of the following:

1. I have the right to revoke this authorization at any time. If I wish to revoke the authorization, I must do so in writing and must provide my written revocation to the Claims Administrator. The written revocation must be signed and dated. The revocation will not apply to any disclosures that already have been made in reliance on this authorization prior to the date upon which the Claims Administrator receives my written revocation.
2. My authorization of the disclosure of the subject Retired NFL Football Player's Protected Health Information is voluntary, which means I can refuse to sign this Form. I do not need to sign this Form to obtain health treatment from any medical provider or to enroll in or be eligible for any health plan benefits. However, I recognize that if I do not sign this Form and submit it to the Claims Administrator, my claim(s) may be denied under the terms of the Settlement Agreement.
3. Any Protected Health Information or other information released to the Claims Administrator may be disclosed to the Special Master, BAP Administrator, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers), may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
4. My Protected Health Information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome ("AIDS"), or human immunodeficiency virus ("HIV"), behavioral or mental health services and treatment for alcohol and drug abuse.
5. This Form is valid from the date of my signature in Section IV until the date that the Claims Administrator performs the last act to process the claim for a Monetary Award that I submitted with this Form.
6. I have a right to receive and retain a copy of this Form.
7. Any photostatic copy of this Form shall have the same authority as the original, and may be substituted in its place.

IV. SIGNATURE

The Retired NFL Football Player or Representative Claimant of the Retired NFL Football Player named in Section II must sign and date this Form below. **By signing below, I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that all information provided in this HIPAA Authorization Form is true and correct to the best of my knowledge, information and belief.**

Signature				Date	<u>09/04/2017</u> (Month/Day/Year)
Printed Name	First 	Last 		Suffix 	

NFL**CONCUSSION SETTLEMENT**IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION
No. 2:12-md-02323 (E.D. Pa.)**AUDIT PROCESS HIPAA AUTHORIZATION FORM**

This Form authorizes the disclosure of "Protected Health Information" as that term is defined in 45 C.F.R. § 160.103. Protected Health Information includes, but is not limited to, information regarding the Retired NFL Football Player's medical care, treatment, physical or mental condition, and medical expenses. By signing and submitting this Form, I authorize the Medical Provider(s) identified in Section I to release all Protected Health Information regarding my (or the Retired NFL Football Player's, if signed by a Representative Claimant) medical care, treatment, physical and mental condition, and medical expenses, to BrownGreer PLC (250 Rocketts Way Richmond, VA 23231), the Claims Administrator in the *In re: National Football League Players' Concussion Injury Litigation* Settlement Program. These records will be used or disclosed solely in connection with the NFL Concussion Settlement Program involving the Retired NFL Football Player named in Section II.

I. MEDICAL PROVIDER INFORMATION

Provider Name	Francis Conidi, MD		
Provider Address	Street		Suite/Unit
	10377 S. US Highway 1		104
	City:	State:	Zip:
	Port St. Lucie	FL	64952

II. RETIRED NFL FOOTBALL PLAYER

Enter the Retired NFL Football Player's information in this Section II.

Settlement Program ID	260006736			
Player Name	First	M.I.	Last	Suffix
	██████████	█	██████████	
Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) of Retired NFL Football Player (if known)	<div style="background-color: black; width: 100%; height: 20px; margin-bottom: 5px;"></div> <div style="text-align: center;">or</div> <div style="display: flex; justify-content: space-between; border-top: 1px solid black; border-bottom: 1px solid black; width: 100%;"> </div>			
	<div style="background-color: black; width: 100%; height: 20px; margin-bottom: 5px;"></div>			
Date of Birth of Retired NFL Football Player	<div style="background-color: black; width: 100%; height: 20px; margin-bottom: 5px;"></div>			

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3. Any Protected Health Information or other information released to the Claims Administrator may be disclosed to the Special Master, BAP Administrator, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers), may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
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Provider Name	Lawrence V. Tucker, MD, PLLC		
Provider Address	Street		Suite/Unit
	4000 MacArthur Blvd., East Tower		600
	City:	State:	Zip:
	Newport Beach	CA	92660

Enter the Retired NFL Football Player's information in this Section II.

Settlement Program ID	260006736
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Player Name	First	M.I.	Last	Suffix
		C		

Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) of Retired NFL Football Player (if known)	<div style="background-color: black; height: 20px; width: 100%; margin-bottom: 10px;"></div> or <div style="border-top: 1px solid black; position: relative; height: 20px; width: 100%;"> </div>
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Date of Birth of Retired NFL Football Player	
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3. Any Protected Health Information or other information released to the Claims Administrator may be disclosed to the Special Master, BAP Administrator, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers), may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
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I. MEDICAL PROVIDER INFORMATION

Provider Name	David J. Chao, MD		
Provider Address	Street		Suite/Unit
	8901 Activity Rd.		
	City:	State:	Zip:
	San Diego	CA	92126

II. RETIRED NFL FOOTBALL PLAYER

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Settlement Program ID	260006736			
Player Name	First	M.I.	Last	Suffix
	██████████	██	██████████	
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Date of Birth of Retired NFL Football Player	<div style="border: 1px solid black; height: 1.2em; width: 100%;"></div>			


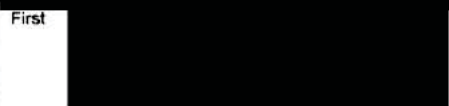

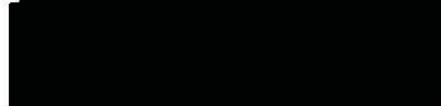

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Signature			Date	<u>09/04/2017</u> (Month/Day/Year)
Printed Name	First 	Last 		Suffix 

AUDIT PROCESS HIPAA AUTHORIZATION FORM

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